Tennessee Department of Children's Services

REQUEST FOR PRIOR APPROVAL OF PRN PSYCHOTROPIC MEDICATION

Child's Name _____ DOB _____Date _____
Social Security # _____ Child's Placement _____

**** THIS FORM MUST BE COMPLETED BY THE PRESCRIBING PROVIDER.****

DSM Diagnosis:

_____

Current Medications: (name, dose, frequency, route)_____

_____

PRN Psychotropic Medication Being Requested: (name, dose, frequency, route)_____

_____

Why is this PRN Psychotropic Medication necessary?_____

_____

What psychiatric symptoms will this medication treat?_____

_____

What behavioral interventions are being used with this child?_____

_____

Under what specific conditions will this medication be administered? _____

_____

How long do you anticipate that this PRN psychotropic medication will be needed? (Not to exceed 14 - 30 days depending on the medication and situation)

_____

How frequently do you anticipate that this PRN psychotropic medication will be needed?

_____

Prescribing Provider's Name _____
Prescribing Provider's Signature _____
Agency Name _____

****APPROVAL MUST BE OBTAINED FROM THE REGIONAL HEALTH UNIT NURSE AND THE DCS DIRECTOR OF MEDICAL AND BEHAVIORAL SERVICES BEFORE THE PRN PSYCHOTROPIC MEDICATION IS ADMINISTERED. INFORMED CONSENT ALSO MUST BE OBTAINED.**

Regional Health Unit Nurse _____

Print Name _____ Date _____

Director of Medical and Behavioral Services _____

Print Name _____ Date _____